

# Valley Surgical Associates

**Madison**  
P: (256) 817-5951  
f: (256) 817-5952

**Huntsville**  
P: 256-265-9491  
f: 256-265-9498

Referral to:

Madison

Huntsville

☐ Matthew Hunt ☐ Douglas Downey

☐ Marc Zelickson ☐ Veeraiah Siripurapu

☐ 8371 Highway 72 W, Suite 206  
Madison, AL 35758  
(Madison Medical 1)

☐ 201 Sivley Road, Ste. 330  
Huntsville, AL 35801  
(Blackwell Medical Tower)

Referral From: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Referral Date: \_\_\_\_\_ Office Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Ins/Primary Name: \_\_\_\_\_

Policy#: \_\_\_\_\_ Grp: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Insurance Information (provide patient information unless patient is a minor, then provide guarantor's information)

PRIMARY INSURANCE

Insurance name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Copay amount: \_\_\_\_\_

Subscriber ID/Contract Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

SECONDARY INSURANCE

Insurance name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Copay amount: \_\_\_\_\_

Subscriber ID/Contract Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Instructions: (Check off to verify done)

- ☐ Referral requested  
(Tricare, HealthSpring, Medicaid etc.)
- ☐ Referring physician office to fax all records related  
to patient's condition
- ☐ Request office to send copy driver's license and  
insurance card with records

- ☐ Patient to bring all medications or list of  
medications to appointment
- ☐ Patient to bring co-pay and/or \$75 if self-pay
- ☐ New patient packet sent

\_\_\_\_\_  
Staff Initials/Date/Time